by reissuing them as 'operations plans' of individual institutions."

-February 21, 1989, OAL Determination No. 3, Docket No. 88-005. OAL found that chapters 100 through 1900 (noninclusive) of the Department of Corrections' Case Records Manual, which establish procedures for use of case records for each inmate, are regulations required to be adopted in compliance with the APA. OAL determined that the challenged rules are standards of general application governing the establishment, maintenance, use, and disposition of inmates' information records which substantially affect all inmates statewide. OAL also found that section 927, entitled "Release to Subsequent Prison Commitments", is not subject to APA rulemaking requirements because this section falls under the internal management exception.

OAL Offers Training. OAL, through the Department of Personnel Administration, is offering classes to state employees on how to conduct a rulemaking action under the California APA. One of the goals of the training program is to promote serious consideration by state agency staff of public comments in the rulemaking process. More than 400 people are expected to receive the training by the end of the fiscal year.

Technical Changes to OAL's Regulations. OAL recently adopted, approved, and filed minor changes to numerous sections of its own regulations, which appear in Title 1 of the CCR. Due to the enactment of AB 2540 (Leonard) (Chapter 1375, Statutes of 1987), which made several amendments to the rulemaking portion of the APA, three types of changes were made to OAL's regulations: (1) changes to statutory section numbers referenced in the regulations; (2) changes in publication names; and (3) other minor clarifying changes. OAL's amendments to Title 1, sections 10-12, 14, 16, 20, 40, 42, 44-46, 56, 84, 86, 90, 100, and 120-28 are effective at this writing.

LITIGATION:

California Chapter of the American Physical Therapy Ass'n, et al. v. California State Board of Chiropratic Examiners, et al. Nos. 35-44-85 and 35-24-14, is still pending in Sacramento Superior Court. Plaintiffs challenge, *inter alia*, OAL's approval of regulatory section 302 of the Board of Chiropractic Examiners' regulations. (See CRLR Vol. 8, No. 3 (Summer 1988) p. 36 for background information.) The court is currently hearing motions for reconsideration of two previous rulings against the Board (*see infra* agency report on BCE for further information).

OFFICE OF THE AUDITOR GENERAL

Acting Auditor General: Kurt Sjoberg
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The Office of the Auditor General (OAG) is the nonpartisan auditing and investigating arm of the California legislature. OAG is under the direction of the Joint Legislative Audit Committee (JLAC), which is comprised of fourteen members, seven each from the Assembly and Senate. JLAC has the authority to "determine the policies of the Auditor General, ascertain facts, review reports and take action thereon...and make recommendations to the Legislature...concerning the state audit...revenues and expenditures...." (Government Code section 10501.) OAG may "only conduct audits and investigations approved by" JLAC.

Government Code section 10527 authorizes OAG "to examine any and all books, accounts, reports, vouchers, correspondence files, and other records, bank accounts, and money or other property of any agency of the state...and any public entity, including any city, county, and special district which receives state funds...and the records and property of any public or private entity or person subject to review or regulation by the agency or public entity being audited or investigated to the same extent that employees of that agency or public entity have access."

OAG has three divisions: the Financial Audit Division, which performs the traditional CPA fiscal audit; the Investigative Audit Division, which investigates allegations of fraud, waste and abuse in state government received under the Reporting of Improper Governmental Activities Act (Government Code sections 10540 *et seq.*); and the Performance Audit Division, which reviews programs funded by the state to determine if they are efficient and cost effective.

RECENT AUDITS:

In March, Acting Auditor General Kurt Sjoberg issued a report criticizing the financial health of the state of California. According to the report, the state loses millions of dollars each year because of inefficiencies in collecting debts, control of expenditures, and management of cash. The OAG audit estimated that California ended fiscal year 1987-88 with a $590 million deficit.

The report also criticizes the differing accounting systems used by state financial reporting agencies. Sjoberg recommends that all agencies use Generally Accepted Accounting Principles, or GAAP. This system is a nationally recognized set of accounting principles which would allow the state to be compared with other states.

The report recommends modifications to a variety of spending restrictions to avoid future fiscal problems. These restrictions include the Gann constitutional spending limit, mandatory education spending levels under Proposition 98, and automatic cost-of-living increases for health and welfare programs.

OAG's report is the latest of several audits which have all reached differing conclusions on the severity of the state's deficit depending on the items considered and the accounting method used. State Controller Gray Davis arrived at a $1.4 billion deficit figure; Legislative Analyst Elizabeth Hill concluded that the state ended 1987-88 with a $200 million deficit; and the Commission on State Finance found a $97 million deficit.

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY (LITTLE HOOVER COMMISSION)

Executive Director:
Jeannine L. English
Chairperson: Nathan Shapell
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The Little Hoover Commission was created by the legislature in 1961 and became operational in the spring of 1962. (Government Code sections 8501 *et seq.*) Although considered to be within the executive branch of state government for budgetary purposes, the law states that "the Commission shall not be subject to the control or direction of any officer or employee of the executive branch except in connection with the appropriation of funds approved by the Legislature." (Government Code section 8502.)

Statute provides that no more than seven of the thirteen members of the Commission may be from the same political party. The Governor appoints five citizen members, and the legislature appoints four citizen members. The balance of the membership is comprised of two Senators and two Assemblymembers.

This unique formulation enables the Commission to be California's only truly

independent watchdog agency. However, in spite of its statutory independence, the Commission remains a purely advisory entity only empowered to make recommendations.

The purpose and duties of the Commission are set forth in Government Code section 8521. The Code states: "It is the purpose of the Legislature in creating the Commission, to secure assistance for the Governor and itself in promoting economy, efficiency and improved service in the transaction of the public business in the various departments, agencies, and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies, and instrumentalities and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...."

The Commission seeks to achieve these ends by conducting studies and making recommendations as to the adoption of methods and procedures to reduce government expenditures, the elimination of functional and service duplication, the abolition of unnecessary services, programs and functions, the definition or redefinition of public officials' duties and responsibilities, and the reorganization and or restructuring of state entities and programs.

MAJOR PROJECTS:

Report on Community Residential Care for the Elderly (January 1989). According to this recent report, we are a rapidly aging society: between 1980 and 2020, the number of Americans over 80 years old will increase from 2.9 million to 7.9 million. The number of California's elderly is increasing more rapidly than in the nation at large, thereby making issues affecting the aged more acute than in most other states.

After its 1983 investigation of the care that society provides for the elderly in residential homes, the Commission released its report, which painted "a grim and ugly picture of neglect, abuse and inadequate government controls...[and] recommended numerous changes designed to protect vulnerable elderly Californians." (See CRLR Vol. 3, No. 4 (Fall 1983) pp. 24-25 for background information.) As a follow-up, the Commission has published this new report, which again reviews conditions in residential care facilities; the result is "only marginally less bleak while the findings regarding the State's role as protector of society's weakest members is every bit as blistering as it was five years ago."

Licensing functions fall to the state Department of Social Services' Community Care Licensing Division. However, unlicensed facilities—which the state plays little or no role in monitoring—present one of the most severe threats to the protection of the elderly. One in six residential care facilities may be unlicensed nationally.

Nevertheless, the state, through its Department of Social Services' Enforcement Program, has no aggressive strategy to eliminate operations which prey upon its senior citizens. The Commission found that in addition to an absence of effective punishments for unlicensed facilities, the state—through its policies and actions—actually provides incentives for them. At the urging of the Commission in 1985, $200-per-day fines for operating without a license were enacted into law, but no regulations have been adopted to impose those fines. In comparison, fines for similar violations in skilled nursing facilities range from $100 to $10,000 per incident. As a result, it is financially advantageous for many residential home operators to begin business without a license. The present licensing process is time-consuming and backlogged, but once an unlicensed facility is discovered, the state's response is to expedite the application process for that operator. The Commission's report condemns the present system, stating that "quality is a low priority in California's Residential Care Regulatory Program. Licensing alone does not constitute a system of controls that could ever prescribe and monitor quality of care in the thousands of residential care facilities throughout the State."

Even when licensed, only 40% of the board and care facilities across the state are visited by "overworked ombudsmen"; in those that are visited, ombudsmen find approximately 550 cases per year of confirmed abuse. Between 500,000 and 1,000,000 abuse cases are reported annually in the nation, representing one in every 25 persons over the age of 60. Thus, approximately 150,000 Californians may be victims of elder abuse. Worse still, reported abuse and violations of regulations are met with an "uneven and lethargic response from the State." For example, paltry fines ($25 or $50 per day) are frequently waived or never collected; no clear coordination exists between the state's oversight function and local prosecution efforts; and no effort is made by the state to inform local referral agencies of license status or regulation violations.

"Clearly, the system is in need of a drastic overhaul." This report makes specific and detailed recommendations, some of which are technical in nature, such as altering fire code requirements and waiving locked-facility regulations. Others suggest broad institutional changes, including the following recommendations:

-Institute a well-coordinated campaign to identify and eliminate unlicensed facilities, and make it a top priority;

-Improve the effectiveness of monitoring and law enforcement;

-Strengthen current law and regulations pertaining to resident protections;

-Enforce existing laws regarding care, and crack down on violations in a timely, uniform, and convincing manner, in part by imposing higher fines and consistently prosecuting transgressors;

-Authorize and fund counties, at their option, to license small residential care facilities and provide placement counseling and assistance;

-Identify new revenue sources from which to increase funding for residential care for the elderly; and

-Demand that those who actually provide care to the elderly be trained and certified under specific education and training requirements, to ensure their capability of meeting the needs of senior citizens. The creation of an all-inclusive (bottom aide to top administrator) professional career ladder would greatly enhance the quality of care in residential facilities.

Report on the Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight (February 1989). Nursing homes should not become an end-of-the-line dumping ground for people. Therefore, the state must be particularly vigilant in shielding the elderly, frail, and friendless from harm and neglect. However, the Commission recently found that "many of the 115,000 persons who are spending their final days in California's nursing homes face poor medical care—or none at all—and there is no one in charge of protecting them." Unfortunately, this subject has not been a major concern of any single state agency or professional organization.

The Commission has twice (1983 and 1987) investigated the state's nursing homes and the overall care they provide. Each time, it made recommendations for changes. This report addresses an issue not fully explored previously—that of the standard of medical care provided to nursing home residents. The Commission found that:

-Some doctors may "visit" 30-50 patients per hour by glancing through charts and signing medication orders;

-Patients may be overmedicated or suffer for weeks from adverse reactions to combinations of drugs before a doctor responds to their changed condition;

-Family members may make repeated calls to doctors, only to be ignored or to have their concerns brushed off as trivial; and

-Sometimes, adequate medical care is provided only after a patient's condition sinks to the life-threatening point and he/she is moved to a hospital.

One reason for these conditions is that some doctors feel overloaded with patients and underreimbursed by Medi-Cal. As a result, they make only cursory efforts or refuse to treat nursing home patients at all. At the same time, nursing home administrators are lobbying to eliminate citations and fines to which they may be subject when necessary medical care is not provided. "They want to be off the hook if, despite what they feel are conscientious efforts, no medical help arrives."

"But if the conditions ... are appalling, the bureaucratic response to them is even more so." The Commission found that the Department of Health Services' Licensing and Certification Division has no tracking mechanism for medical care complaints; no coordinated recordkeeping for such cases; no guidelines for what constitutes proper medical care; and insufficient personnel and expertise to make a difference. Medical care in nursing homes is not a top priority for the Division.

Nor has the Board of Medical Quality Assurance (BMQA) taken up the banner. Indeed, the Commission found BMQA to be "singularly inactive in this area, having neither adopted standards of care for nursing homes nor instituted a fine and citation system for those who fail to provide adequate care." (*See supra* FEATURE ARTICLE for further information on this issue.)

According to the report, the state has failed the elderly, and no other person, group, or organization has stepped in to advocate the needs of this very vulnerable population. The Commission recommends that steps be taken to create a responsive monitoring system which would encourage good medical care in nursing homes, and to increase the number of doctors trained in geriatrics and willing to specialize in treating the elderly. Eighteen specific recommendations were made, including the following:

-Nursing homes should be required to set up peer review systems for doctors who provide medical care in their facilities;

-Medical directors of nursing homes should be limited to handling only up to 400 beds or floor facilities;

-The Licensing and Certification Division should convene an ad hoc committee to create standard-of-care guidelines;

-BMQA should be required to implement a fine and citation system that reflects the Division's guidelines;

-The Licensing and Certification Division and BMQA should be required to develop better mechanisms to track cases and coordinate records;

-Continuing education course requirements in geriatrics and chronic care should be imposed on all doctors who treat more than five nursing home patients within six months; and

-A fund should be established to increase the availability of medical care to the elderly by attracting doctors into the geriatrics field.

Public Hearing on the State's Boards, Commissions, and Authorities. On February 24 in Sacramento, the Commission heard testimony (from which a report will be released) regarding the state's boards, commissions, and authorities, including the following and related topics: criteria for determining the need for a multiple-member policy or regulatory agency; criteria for the initial establishment of a board or commission; methods of evaluating the effectiveness of boards and commissions; and use of "sunset" criteria for each of the various types of boards, commissions, and authorities.

Professor Robert C. Fellmeth, Director of the Center for Public Interest Law, was among those testifying. Prior to creating a new regulatory/licensing agency, Fellmeth stated, the following tests should be met:

-In deciding whether to regulate, the precise market flaw justifying such action must be identified.

-The spectrum of possible and alternative societal mechanisms to redress the identified flaw, including the efficacy, costs, and benefits of each, must be considered.

-Because the licensing alternative is an extraordinary intrusion into the marketplace, operating as a "prior restraint", it should be presumptively disfavored. Licensing should be chosen only where irreparable harm to others would be likely without the prior restraint; the prior restraint is precisely directed at and will likely lessen that harm; the prior restraint is a more cost-effective means to lessen the harm than are the alternatives; and the total benefits of the system exceed its total costs.

-Once the regulation system chosen is instituted, care should be taken to avoid expansion beyond its defensible justification.

-Multi-member bodies are preferable to directorates because open decisionmaking after public discussion are required of the former. At minimum, an advisory board should be established to advise single persons with rulemaking and adjudicatory powers.

-No person who is a currently practicing member of a profession should be a state official or member of the board regulating that profession, so as to guard against any present vested personal profit stake in decisionmaking. Agency staff and comment from the profession regulated should provide expert advocacy—where necessary—to a neutral policymaking board.

DEPARTMENT OF CONSUMER AFFAIRS

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In addition to its functions relating to its forty boards, bureaus and commissions, the Department of Consumer Affairs (DCA) is charged with the responsibility of carrying out the provisions of the Consumer Affairs Act of 1970. In this regard, the Department educates consumers, assists them in complaint mediation, advocates their interests in the legislature, and represents them before the state's administrative agencies and courts.

MAJOR PROJECTS:

Dispute Resolution Program. This DCA-sponsored program consists of a network of informal and affordable county-based mediation centers throughout the state, based on the idea that an impartial mediator can often help adversaries reach a mutually satisfactory settlement. It is hoped that the program will defuse many disagreements which might otherwise end up in an already crowded state court system. (See CRLR Vol. 8, No. 2 (Spring 1988) p. 33 for background information.) Presently, seventeen counties participate in the program with a total of 21 funded programs.

The program gained widespread publicity in March as a result of an article published in *California Lawyer* entitled "Dog Cases", referring to the cases taken by community mediators which have been rejected by lawyers. The article notes the dramatic growth in mediation services across the state, due largely to the funding provided by the Dispute Resolution Program. Twelve years ago,